

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

MEMORANDUM

TO: Applicants for Surgical Assistant Certification

FROM: Dawn Beahl, Surgical Assistant Coordinator

RE: Certification as a Surgical Assistant

Enclosed is an application for certification as a surgical assistant in the Commonwealth of Kentucky. You are requested to complete the application, sign and have the form notarized. The completed application is to be returned along with the following information:

- Completed application must be **signed and notarized**. Please note that the Board publishes your certification information on our website. This information is used for verification purposes. Please indicate your practice address on the application. If no practice address is listed, your mailing address will be published.
- Recent original photograph of yourself (**passport size**) **signed and dated**.
- FORM 1: Verification of national certification.
Please note that in accordance with KRS 311.878, as of July 1, 2006, certification from the American Board of Surgical Assistants (ABSA) will no longer be accepted.
- FORM 2: Verification of full-time work experience performed in this country under the direct supervision of a physician licensed in this country and consisting of at least 800 hours of performance as an assistant in surgical procedures for the three (3) years preceding the date of the application

Once the application has been received and is complete, it will be presented to the Kentucky Advisory Committee for Surgical Assistants for their consideration. If the Committee determines that you have met the statutory requirements for certification, your application will then be presented to the Kentucky Board of Medical Licensure for final approval.

For your information the fee for certification is:

- \$50.00 Initial Certification Fee – **Checks should be made payable to the Kentucky Board of Medical Licensure**

Should you have any questions regarding the application, please contact me at (502) 429-7150.

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APPLICATION FOR SURGICAL ASSISTANT CERTIFICATION IN KENTUCKY
(Please Type or Print)

1. Name: _____
(first) (middle) (last)

2. Mailing Address _____
(street) (city) (state) (zip)

3. *Practice Address _____
(street) (city) (state) (zip)

***The practice address will be published on the Board's website for your surgical assistant profile.**

4. Social Security Number: _____ - _____ - _____

5. Phone: (home) _____ (work) _____

6. Place of Birth _____ Date of Birth _____

7. Employment History: Beginning with the most recent, include all surgical assistant employment from NSAA/NBSTSA certification to date of this application. Attach additional sheets if necessary.

Dates: From – To _____ Position Held _____

Business Address _____

Type of Practice _____ Phone _____

List Duties Performed in Practice _____

8. Have you completed an educational program approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) in surgical assisting? ☐ YES ☐ NO

If yes, name of program: _____
City State Date of Graduation

9. Have you completed an educational program approved by the United States Military? ☐ YES ☐ NO

10. Are you currently certified by one of the following:

The National Surgical Assistant Association ☐ YES ☐ NO

National Board of Surgical Technology and Surgical Assisting ☐ YES ☐ NO

If Yes, Certification # _____ Expiration Date _____

11. List all states in which you have applied for or been granted certification/license as a surgical assistant.

State	Certification #	Issue Date	Expiration Date
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_____	_____	_____	_____
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_____	_____	_____	_____
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Name _____ Social Security Number _____

If you answer “YES” to questions (#12 – 17), or questions (#1-5) on the next page, please attach a written explanation.

12. Have you had any certificate, license, registration or other privilege to practice as a health care professional, denied, revoked, suspended, probated, or restricted by a State or Federal authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/action by such jurisdiction? ☐ YES ☐ NO
13. Have you been or are you currently under investigation by any State or Federal licensure authority or any drug licensure/enforcement authority? ☐ YES ☐ NO
14. Are any legal proceedings regarding certification/licensure presently pending against you by any State or Federal licensure authority or any drug licensure/enforcement authority? ☐ YES ☐ NO
15. Have you been convicted of a felony or misdemeanor by any State or Federal court? Are any criminal charges presently pending against you in any of those courts? ☐ YES ☐ NO
16. To your knowledge, are you the subject of an investigation for a criminal act? ☐ YES ☐ NO
17. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Authority? ☐ YES ☐ NO

AFFIDAVIT OF APPLICANT: I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board, or its agents, to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now, or in the future, have concerning my qualifications and fitness to practice as a surgical assistant to any person, institution, association, school, hospital or government entity. I understand any false information on my application may subject my certification to disciplinary action pursuant to the Kentucky Certified Surgical Assistant Statutes

Signature of Applicant

Date

Subscribed and sworn before me by the above named applicant this

_____ day of _____, _____

This application consists of 3 pages.

Signature of Notary

My commission expires: _____

Seal of Notary

*This Application is in compliance with the American Disabilities Act
(10/21/04) (1/05/05) (7/6/06) (8/19/08)

Name _____ Social Security Number _____

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a certification decision based upon them.

“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
☐ Yes ☐ No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
☐ Yes ☐ No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
☐ Yes ☐ No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
☐ Yes ☐ No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
☐ Yes ☐ No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice as a surgical assistant to any person, institution, association, school, hospital or government entity.

(Signature of Applicant)

(Print Name)

Subscribed and sworn to before me by the above named applicant this _____ day of _____
(month, year)

(Signature of Notary)

Seal of Notary

My commission expires: _____

• • • **DEADLINES FOR COUNCIL MEETING DATES** • • •

In order for your application to be presented to the State Advisory Committee on Surgical Assistants, your application must be completed in its entirety and must be on file in the Board office no later than the deadline dates listed below. Once the Committee reviews your application, it will be presented to the Kentucky Board of Medical Licensure for final approval.

<u>Deadline Date</u>	<u>Meeting Date</u>	<u>Board Meeting Date</u>
October 17, 2008	November 14, 2008	December 18, 2008
January 15, 2009	February 5, 2009	March 19, 2009
April 17, 2009	May 8, 2009	June 18, 2009
July 17, 2009	August 6, 2009	September 17, 2009
October 16, 2009	November 6, 2009	December 17, 2009

**Surgical Assistant Verification
Waiver Release Form**

Applicant: Complete the top portion of this form. Please see enclosed insert regarding address information.

Name: _____

Address: _____

Certification #: _____

Applicant Signature

I authorize the Surgical Assistant certifying Board to release to the Kentucky Board of Medical Licensure all of the information requested below.

Verification of Surgical Assistant Certification

As Executive Director for a Surgical Assistant Certifying Board, I hereby attest that the above named applicant has successfully passed a Surgical Assistant Certification Examination and has been assigned the following:

Name: _____

SA Certification Number: _____

Certification Type: _____

Certification Date: _____

Expiration Date: _____

Certification in Good Standing? ☐ Yes ☐ No

If the answer is "NO" to the above question, please provide additional information

Surgical Assistant Certifying Board Signature

Date

Name of Certifying Board

Please mail form directly to: Kentucky Board of Medical Licensure
Attn: Dawn R. Beahl, Surgical Assistant Coordinator
310 Whittington Pkwy., Suite 1B
Louisville, KY 40222

Surgical Assistant Verification
Insert for Form 1

If you have met the surgical assistant requirements by receiving certification from ***The National Surgical Assistant Association***, please complete and mail Form 1 to:

National Surgical Assistant Association
2615 Amesbury Rd.
Winston-Salem, NC 27103
(888) 633-0479

If you have met the surgical assistant requirements by receiving certification from ***The National Board of Surgical Technology and Surgical Assisting*** (formerly *The Liaison Council on Certification for the Surgical Technologist*), please complete and mail Form 1 to:

The National Board of Surgical Technology and Surgical Assisting
6 West Dry Creek Circle, Suite 100
Littleton, CO 80120
(800) 707-0057

Verification of Surgical Assistant Hours

Applicant: Please complete this section of the form and mail entire form to a physician licensed in the United States with whom you completed your hours for the three (3) years preceding the date of the application. If needed, you may copy this form for additional copies.

As a part of the application for certification as a surgical assistant, the Kentucky Board of Medical Licensure requires this form be completed verifying that I have completed at least eight hundred (800) hours of performance as an assistant in surgical procedures for the three (3) years preceding the date of the application. I, hereby authorize the release of any information in your files, favorable or otherwise, to be **sent directly to the Kentucky Board of Medical Licensure, Attn: Dawn R. Beahl, Surgical Assistant Coordinator, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222**

Applicant's Name: _____

Address: _____

Do Not Detach

Name of Applicant: _____

Hospital where completed Hours:

Address of Hospital

Total Number of Hours Completed: _____

Date began hours: _____ Date completed hours: _____

Name of Physician Supervising Hours: _____

State of License: _____ State License No: _____

Title: _____

Signature: _____

*** Please note that this form must be completed by the physician supervising the surgical assistant. Verification will not be accepted by anyone other than a licensed physician.**